Welcome to Eye Love Optical and Dr. Michael Stewart, Optometrist

EYE LOVE OPTICAL
Michael Stewart, O.D.

Today's Date_____

Personal Information

_____

Last name First name MI Date of Birth

Health History

Date of Last Physical _____ Name of Physician _____

Have you had or do you currently have any of the following conditions?

- ☐ Diabetes
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Thyroid Problem
- ☐ Anxiety/Depression
- ☐ Hepatitis
- ☐ Respiratory Problems
- ☐ Stroke/Neurological
- ☐ Cardiovascular Problems
- ☐ Blood Clot/Bleeding
- ☐ Sickle Cell/Anemia
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Kidney Problems
- ☐ Skin Disorders
- ☐ Are you Pregnant?
- ☐ HIV/AIDS
- ☐ Arthritis
- ☐ Lupus
- ☐ Fever
- ☐ Excessive Weight Gain
- ☐ Excessive Weight Loss
- ☐ Migraines
- ☐ Seizures
- ☐ Fever
- ☐ Allergy/Hay Fever
- ☐ Chronic Congestion
- ☐ Chronic Cough
- ☐ Dry Throat/Mouth
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Diarrhea
- ☐ Constipation
- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Other

Please explain any checked

_____

_____

Date of Last Eye Exam _____ Name of Eye Doctor _____

Have you ever been treated for or diagnosed with any of the following?

- ☐ Cataracts
- ☐ Amblyopia/Lazy Eye
- ☐ Strabismus/Crossed Eye
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Problems
- ☐ Eye Infection
- ☐ Eye Surgery
- ☐ Eye Trauma
- ☐ Color Blindness

Do you experience any of the following?

- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Light Sensitivity
- ☐ Burning
- ☐ Itchy Eyes
- ☐ Tearing
- ☐ Redness
- ☐ Flashes of Light
- ☐ Floaters
- ☐ Eye Pain
- ☐ Headaches
- ☐ Eye Infections
- ☐ Loss of Vision
- ☐ Sandy/Gritty Feeling
- ☐ Bumps on Eye Lid

Do you have a FAMILY history of the following?

- ☐ Diabetes
- ☐ Hypertension
- ☐ Blindness
- ☐ Glaucoma
- ☐ Amblyopia/Lazy Eye
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Strabismus/Crossed Eyes
- ☐ Cataracts

List Medications:	List Allergies:

Patient (or Parent/Guardian if under 18) Signature _____